# Fletcher Fund
# Application

---

Attached is an application for the Organ Recipients of SW Fl. Inc.'s Fletcher Fund.

Individual disbursements are currently capped at $300.00. Yearly disbursements are currently capped at $1,500.00. Only members of Organ Transplant Recipients of SW Fl. may apply.

Applications for group 1 expenses will receive the highest priority. Group 2 expenses will receive middle priority and group 3 expenses will receive lowest priority.

**Group 1** (High Priority)

Medications and Medical Related Expenses

**Group 2** (Middle Priority)

Lodging, Meals, and Transportation To and From Medical Facilities

**Group 3** (Low Priority)

Household and Transplant Miscellaneous Expenses

Completed applications delivered to any Fletcher Fund Trustee will be considered at the Trustee's next regularly scheduled meeting.

# Fletcher Fund
# Request for Assistance

## *PERSONAL INFORMATION*

Name: _____

Local Address: _____

City: _____County: _____

State: _____Zip: _____

Social Security Number: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Present Employer: _____

Work Phone: _____

Supervisor: _____

Full time or part time resident? _____

Alternative Address: _____

City: _____ County: _____

State: _____ Zip: _____

Caregiver's Name_____

Caregiver's Relationship: _____

Caregiver's Home Phone: _____

Caregiver's Cell Phone: _____

## *FINANCIAL INFORMATION*

Combined Monthly Household Income – After Taxes

| | | |
|---|---|---|
| Wages: $_____ | Social Security: $_____ | Other: $_____ |
| Disability: $_____ | Investments: $_____ | |

| *OTHER FINANCIAL RESOURCES* | *ESTIMATED TOTAL MONTHLY LIVING EXPENSES & LIABILITIES* |
|---|---|
| Previous Fundraising Activities: $_____ | Do you rent or own your residence? _____ |
| Total Liquid Assets (stocks, bonds etc.): $_____ | Monthly Rent or Mortgage: $_____ |
| Other: $_____ | Average Total of Monthly Utilities: $_____ |
| | Monthly Vehicle Payment $_____ |
| | Monthly Med Insurance Payment: $_____ |
| | Monthly Other: $_____ |

## *PATIENT INSURANCE INFORMATION*

Medical ins. name: _____ Insurer ph. number: _____

Policy name & number: _____ Date issued: _____

Will heath insurance provide coverage: _____

If yes, in what capacity? 100%_____ 90/10_____ 80/20_____ Other_____

If no, please provide insurer determination letter.

Does insurance provide a travel and/or lodging benefit? _____

If yes, what limit? _____

Life insurance amount? _____ Insurer/Company name: _____

Policy name & number _____ Date Issued: _____

## *PATIENT TRANSPLANT INFORMATION*

Diagnosis: _____

Date of Diagnosis: _____ Type of Transplant _____

Are you on a transplant waiting list? _____

Have you already received a transplant? _____ If so date of transplant: _____

Transplant Center? _____

City: _____ State: _____ Phone: _____

Treating Physician: _____ Phone: _____

***REQUEST INFORMATION***

Amount requested: $_____for payment to _____

Reason for the request: _____
_____
_____
_____
_____

Please attach all relevant bills, invoices and/or insurance explanation of benefits forms.

_____
Date

_____
Print Name

_____
Signature

**AUTHORIZATION OF RELEASE INFORMATION**

**I HEREBY AUTHORIZE** the Fletcher Fund complete and total access to any and all records confidential or otherwise needed to determine my eligibility. Any person in possession of any record or information about me upon presentation of this Authorization is hereby instructed to furnish copies of my complete file and any other information.

_____ _____
Print Name / Signature Date